

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-011985
STATE FILE NUMBER

FILED APR 15 1959

Registration District No.

333

Primary Registration District No.

4488

Registrar's No.

62

1. PLACE OF DEATH a. COUNTY <u>SCOTT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MO</u> b. COUNTY <u>Scott</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>VANDUSER</u>		c. CITY OR TOWN <u>VANDUSER</u>	
c. FULL NAME OF (IF NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Home</u>		d. STREET ADDRESS (If outside, give location) <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>WALLACE</u> Middle <u>M.</u> Last <u>HARRISON</u>		4. DATE OF DEATH Month <u>4</u> Day <u>6</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-28-1897</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (City and state or country) <u>DENNIS MISS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13a. FATHER'S NAME <u>C.C. HARRISON</u>		13b. MOTHER'S MAIDEN NAME <u>AMANDA SAVAGE</u>	
14. NAME OF HUSBAND OR WIFE <u>RESSIE LEE</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>	
16. SOCIAL SECURITY NO. <u>425-26-8891</u>		17. INFORMANT <u>Mrs. Ressie L. Harrison Vanduser Mo</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shock pneumonia.</u> DUE TO (b) <u>Chronic Bronchitis</u> DUE TO (c) <u>Bronchiogenic Carcinoma</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <u>Chronic Emphysema</u>		INTERVAL BETWEEN ONSET AND DEATH <u>5 MINUTES</u> <u>2 DAYS</u> <u>6 MONTHS</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) <u>—</u>	
20c. TIME OF INJURY Hour <u>—</u> Month, Day, Year <u>—</u> a.m. <u>—</u> p.m. <u>—</u>		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. CITY, TOWN, OR LOCATION <u>—</u>	
21. I attended the deceased from <u>11-59</u> to <u>4-6-59</u> and last saw him alive on <u>4-2-59</u> Death occurred at <u>9:20 A.M.</u> on the date stated above; and to the best of my knowledge, from the causes stated.		22. ADDRESS <u>Advance MO</u>	
23a. SIGNATURE <u>J. G. Masters D.O.</u>		23b. DATE SIGNED <u>4-6-59</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>JOEL CEMETERY</u>		23d. LOCATION (City, town, or county) (State) <u>DENNIS MISS</u>	
24. FUNERAL DIRECTOR <u>Welsh Funeral Home - Skeeton Mo</u>		25. DATE RECD. BY LOCAL REG. <u>4-8-59</u>	
26. REGISTRAR'S SIGNATURE <u>Mrs. Ella Hunter</u>		27. DATE SIGNED <u>—</u>	

300
1-57
4-20-59
All diseases in Part I must be causally related.
USE ONLY BLACK INK OR PENCIL IF POSSIBLE

MEDICAL CERTIFICATION

APR 22 1959

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed _____

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.